

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-018358

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4892

STATE FILE NUMBER

VS 300  
Rev. 4/59

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>Clayton, Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>21 Arundel Place</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret Mary Watson</b>		4. DATE OF DEATH Month Day Year <b>May 4 1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/20/1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reg. Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Andrew H. Watson</b>		13b. MOTHER'S MAIDEN NAME <b>Molly Breman</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Lester Watson, 1015 Boland Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> DUE TO (b) <b>Thrombosis of left arm</b> DUE TO (c) <b>Carcinoma of Breast</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>170X</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>9/3/47</b> to <b>5/4/63</b> and last saw her alive on <b>5/4/63</b> Death occurred at <b>2:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert Potashnick M.D.</b>		22b. ADDRESS <b>3720 Washington</b>	
22c. DATE SIGNED <b>5/6/63</b>		22d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 7, 1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 6 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		27. ADDRESS <b>3840 Lindell Blvd.</b>	

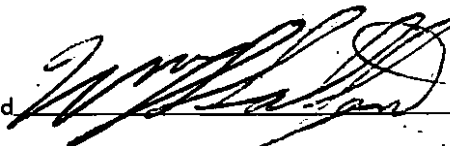
DR. POTASHNICK  
3730 Washington

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed



Licensed Embalmer No.

4689

P. O. Address

3840 1st St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.